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Dear Colleague

GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATES OF THE CAUSE OF DEATH (MCCD) AND ITS QUALITY ASSURANCE

Purpose

1. This composite letter provides you with information regarding several areas outlined below, to avoid the need to send repeated CMO letters:

- Updated joint guidance from the Scottish Government and the National Records of Scotland (NRS) (paragraph 2)
- Updated Crown Office and Procurator Fiscal Service (COPFS) guidance for doctors to report certain deaths to the Procurator Fiscal (PF) (paragraph 4)
- Guidance, attached in the **Annex**, on the new quality assurance system of scrutiny of the MCCDs which is anticipated to start on 29 April 2015; and
- Subsequent legislation (paragraphs 6 and 8).

2. As you are aware, the accurate completion of the Medical Certificate of the Cause of Death (MCCD or Form 11), by the medical practitioner to the best of his/her knowledge and belief, is a statutory requirement for all registered doctors. COPFS has been consulted about the joint CMO/NRS guidance for doctors completing MCCD and its quality assurance.

3. Details of the changes to the MCCD and information about electronic completion of MCCDs were provided in the CMO letter of 25 June 2014, which can be accessed through the link below:
[http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)16.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)16.pdf)

4. At the same time, COPFS also consulted with the medical profession while developing its own guidance on reporting certain deaths to the PF. The COPFS document called "[Reporting Deaths to the Procurator Fiscal – Information and Guidance for Medical Practitioners](#)" is intended to provide a clear and concise guide to doctors in deciding whether a death requires to be reported to the PF and the process to be followed.

From the Acting Chief Medical Officer
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16 October 2014

SGHD/CMO(2014)27

Addresses

For action

NHS Boards and Special Health Boards Medical Directors to cascade to all doctors
NHS Board Local Implementation Leads for Death Certification

For information

Directors of Public Health, NHS Boards
Chief Executives, NHS Boards and Special Health Boards
Chairs, NHS Boards
NRS
COPFS
Primary Care Leads, NHS Boards
NHS Bereavement Co-ordinators
Central Legal Office
Regulation of Independent Healthcare Services
MDDUS
MPS
MDU
GMC
BMA Scotland
Academy of Medical Royal Colleges and Faculties in Scotland
Hospices
Private hospitals
Police Scotland
SG Senior Medical Officers
Forensic Physicians

Background

5. In 2007, the Scottish Government established the Burial and Cremation Review Group to review the Cremation Acts of 1902 and 1952 (and the Cremation (Scotland) Regulations 1935, as amended), and the Burial Grounds (Scotland) Act 1855. The Group's report in October 2007 made several recommendations to the Scottish Government on how to update and modernise the legislation in order to better serve the needs of the people of Scotland.

6. As a consequence, the Certification of Death (Scotland) Act 2011 ("the 2011 Act") was introduced to update the first phase of the Certification of Death process in Scotland. Details of the aims of the legislation can be accessed through the website below.

<http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

Work is now commencing on a second piece of legislation to address the remaining recommendations of the Burial and Cremation Review Group relating to burial, cremation, disposal of remains and other aspects of the funeral processes.

7. On 20 March 2014 the Chief Medical Officer issued a letter explaining the initial actions to be taken to implement the Certification of Death (Scotland) Act 2011, through Health Board Implementation Leads. This is available at: [http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)08.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)08.pdf)

8. Cremation forms B and C **will not be required** in Scotland, from the date the Certification of Death (Scotland) Act 2011 comes into effect, irrespective of where the death occurred. The 2011 Act is anticipated to come into force on 29 April 2015.

Action

9. We would be very grateful if the attached national guidance, which **replaces** the previous guidance of 29 September 2009 (SGHD/CMO(2009)10) and 18 October 2011 (SGHD/CMO(2011)13), could be circulated widely among medical staff within your Health Board area. NHS Education Scotland (NES) has produced a summary version of the detailed guidance, available at: http://www.nes.scot.nhs.uk/media/2736701/mccd_power_point.pdf

10. Finally, we wish to thank you, particularly the Implementation Leads in the Health Boards, for all your hard work in ensuring the smooth implementation of the new MCCD on 6 August 2014.

Yours sincerely

Aileen Keel

Tim Ellis

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**GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATES OF
THE
CAUSE OF DEATH AND ITS QUALITY ASSURANCE**

**ADVICE FROM THE CHIEF MEDICAL OFFICER AND NATIONAL RECORDS
OF SCOTLAND**

THE SCOTTISH GOVERNMENT

OCTOBER 2014

GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATES OF THE CAUSE OF DEATH AND ITS QUALITY ASSURANCE

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<p style="text-align: center;">GUIDANCE FOR MEDICAL STAFF COMPLETING MEDICAL CERTIFICATES OF THE CAUSE OF DEATH (MCCD or Form 11)</p>
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1. THE PURPOSES OF DEATH CERTIFICATION

Death certification serves a number of functions. A Medical Certificate of Cause of Death (MCCD) as in **Annex 1**, providing the required information to the best of the medical practitioner's knowledge and belief, is a statutory requirement. This provides a permanent legal record of the fact of death and enables the family to register the death, make arrangements for the disposal of the body, and settle the deceased's estate. Timely and accurate completion of MCCDs is of great help to the bereaved families and friends as it reduces undue additional distress at an extremely difficult time.

Information from MCCDs is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths by **underlying cause** is important for monitoring the health of the population, designing and evaluating public health interventions, recognising priorities for health services and medical research, planning health services, and assessing the effectiveness of those services. Data from the MCCDs are extensively used in research into the health effects of exposure to a wide range of risk factors through the environment, work, medical and surgical care, and other sources.

Following a death the "informant", who is the person who registers the death, and who may be the next of kin or one of a number of different persons qualified to fulfil this role, is provided with the MCCD which they must take to the registrar's office to register the death within 8 days of the death being verified. After registering the death, the next of kin gets a certified copy of the register entry, called the "Certificate of Registration of Death", (also referred to as Form 14 and sometimes **incorrectly** called the "death certificate"), which includes an exact copy of the cause of death information given by the certifying doctor. This provides them with an explanation of how and why their relative died. It also gives them a permanent record of information

about their family's medical history, which may be important for their own health and that of future generations. For all of these reasons it is extremely important that you provide clear, accurate and complete information about the diseases or conditions that caused your patient's death, as well as the supporting administrative data required on the MCCD and outlined in section 7 of this guidance.

GMC's guidance also expects doctors to be honest and trustworthy when completing or signing forms, taking reasonable steps to check that the information is correct and not false or misleading. Relevant information should not be deliberately left out. A link to the [GMC Good Medical Practice](#)¹ guidance (particularly paragraph 71).

The MCCD is a legal document and the information provided in it should be accurate to the best of your knowledge and belief.

The 8-digit serial number on each MCCD is made up of a unique seven digit sequential serial number (from the left, digits 1-7) and an additional eighth "check" digit last number on the right, which is randomly generated for a computer system to use to identify mis-keyed serial numbers. The last digit in this serial number is a random check digit generated to ensure each form is unique. This final digit should be ignored when comparing serial numbers: for example, the ordering of the serial numbers within books (and tracked by range of 7-digit serial numbers which is printed on the book cover) is sequential when the final check digit is ignored. Any final "check digit" which is an alphabetic character (such as 'X') is also part of the randomly-generated check digit function, and can safely be ignored when matching the first 7 digits of the 8-digit serial numbers on the forms to the range of 7-digit serial numbers on the book cover. This digit is currently not included in the "Record of Issue" section. The MCCD is a double sided form with the serial number currently not included on both sides. Caution should be exercised while faxing as the 2 sides may get inadvertently separated and/or combined with incorrect pages.

¹ http://www.gmc-uk.org/guidance/good_medical_practice.asp

NHS Education for Scotland (NES) has developed some [educational resources](#)² to assist in the completion of the MCCD.

This guidance is also available from the National Records of Scotland (NRS) [link](#)³ in the MCCD or directly via the [Certification of Death \(Scotland\) Act 2011](#)⁴ website.

Additional information regarding good medical practice is available from the The [General Medical Council](#)⁵(GMC) website.

Legislation for the MCCD is from the powers in the [Registration of Births, Deaths and Marriages \(Scotland\) Act 1965](#)⁶.

Additional MCCD forms can be ordered directly from NRS (their Local Organisation Unit - LOU) as required. The contact email and telephone number are:

e-mail: lou@gro-scotland.gsi.gov.uk

telephone: 0131 314 4462

2. CHANGES TO DEATH CERTIFICATION

The [Certification of Death \(Scotland\) Act 2011](#)⁷ is intended to improve the quality of MCCDs through quality assurance of the MCCD undertaken by an independent medical review system, comprising a team of Medical Reviewers (MRs), a Senior Medical Reviewer (SMR) and Medical Reviewer's Assistants (MRAs).

The aims of the legislation are:

- To implement a new death certification system in Scotland which will introduce a single system of independent effective scrutiny, applicable to all

²[http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/generic-training/support-of-national-training/the-certification-of-death-\(scotland\)-act-2011-education-and-learning-resources.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/generic-training/support-of-national-training/the-certification-of-death-(scotland)-act-2011-education-and-learning-resources.aspx)

³ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

⁴ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

⁵ http://www.gmc-uk.org/guidance/good_medical_practice.asp

⁶ <http://www.legislation.gov.uk/ukpga/1965/49>

⁷ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

deaths excepting stillbirths and those that require to be reported to the Procurator Fiscal (PF);

- To improve the quality and accuracy of MCCDs;
- To strengthen clinical governance in relation to deaths; and
- To provide improved public health information.

Therefore, neither burials, cremations nor any other method of disposal, nor any funeral can go ahead without registration of the death.

Following the implementation of the Certification of Death (Scotland) Act 2011(which is expected to be on the 29 April 2015), there will be 2 levels of random independent reviews of the MCCD

Level 1 - a basic shorter review, currently of 10% of all deaths

Level 2 - a comprehensive review, of at least 1,000 deaths per year, with additional reviews for cause such as those requested by “Interested Persons” as described in legislation and by MRs/SMR themselves (**see Annex 2, section 8**) i.e. about 2,000 deaths (around 4%) per year.

The MCCDs for review will be selected at random by NRS at the time the death is registered by the informant. Where available, an electronic MCCD can be completed and will be automatically transferred to NRS. You are required to complete the MCCD promptly for everyone, as death registration must be finalised for the funeral arrangements to proceed. It is particularly important for those cases randomly selected for review as death registration cannot be undertaken until the review process has been completed. A Level 1 review will normally be completed in one working day, which includes the time taken to access the necessary information and contact the certifying doctor. A Level 2 review is expected to be completed in 3 working days, although the actual time spent on the review itself will be much less. If the certifying doctor is not available, another member of the clinical team with knowledge of the deceased and/or access to the relevant clinical records can be contacted. Sometimes the MR may agree to expedite the review, when requested to do so by the relatives where religious, cultural, compassionate, or practical criteria are satisfied. An MCCD may also be selected for review by a MR, following

consideration of a request by an “Interested Person” such as a family member. **Details are included in Annex 2.**

When the Certification of Death (Scotland) Act 2011 is implemented, it will also include the removal of the statutory cremation forms B and C, as well as the statutory scrutiny role of Crematoria Referees. From that time, B and C cremation forms will not be required in Scotland, wherever the death may have occurred.

3. WHO SHOULD CERTIFY THE DEATH?

When a patient dies it is the statutory duty of the doctor, who has “attended” the deceased during the last illness, to issue the MCCD. There is no clear legal definition of “attended”, but it is generally accepted to mean a doctor who has cared for the patient during the illness or condition that led to death and so is familiar with the patient’s medical history, investigations and treatment. The certifying doctor should also have access to relevant medical records and the results of investigations. There is no provision under current legislation to delegate the statutory duty of providing an MCCD to any non-medical staff.

There are circumstances where it is not possible for the doctor who was in attendance to provide the certificate (in this case “box A2” should be ticked), or no doctor was in attendance (in this case the relevant “box A3” should be ticked). In these circumstances another doctor in the team, with knowledge of the deceased and/or access to the relevant clinical records, can complete the MCCD. MCCDs completed by a pre-registration doctor in training (FY1), which require the involvement of a senior doctor. The Consultant in charge of the patient’s care must also be made aware of all deaths which result in a report to the PF. MCCDs should be completed by a member of the team that know the deceased wherever possible and practical e.g. the day team in a hospital.

Discussion of a case with an experienced colleague may help to clarify issues related to the completion of the MCCD. Alternatively, after the full implementation of the Certification of Death (Scotland) Act 2011, MRs can be another source of advice.

In hospitals, there may be several doctors in a team or several teams caring for the patient before death. The Consultant in charge of the patient's care is ultimately responsible for ensuring that the death is properly certified. Any subsequent enquiries about the patient, such as results of ante-mortem or post-mortem investigations, will initially be addressed to you as the certifying doctor. If you are not available then the Consultant in charge of the patient's care will be contacted. In general practice, more than one GP may have been involved in the patient's care and so be able to certify the death. If not, the doctor with access to the relevant clinical records can complete the MCCD.

Pathologists completing the MCCD should tick "box A2 or A3" as appropriate.

In the UK, the MCCD of the country where the patient died and where the death will be registered should be used.

4. REPORTING A DEATH TO THE PROCURATOR FISCAL

The Procurator Fiscal (PF) has a duty to investigate certain deaths, such as those which are sudden, suspicious, accidental and/or unexplained. The categories of deaths which should be reported to the PF are contained within the PF guidance ["Reporting Deaths to the Procurator Fiscal, Information and Guidance for Medical Practitioners"](#)⁸.

Contact details for the Scottish Fatalities Investigations Unit (SFIU) teams of the Crown Office and Procurator Fiscal Service (COPFS) to whom a death should be reported are provided within the above guidance.

Tick the box "Procurator Fiscal PF", if you or your colleague have **reported** the death to the PF according to the [PF guidance](#)⁹. Please ***do not tick the box if you have consulted the Procurator Fiscal only for advice, and following discussions with the Procurator Fiscal it has been agreed that the circumstances of the***

⁸<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

⁹<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

death in question is not reportable. However, please ensure that the discussion with the Procurator Fiscal is recorded in the clinical records of the deceased patient.

Please also note that “children”, in the context of reporting to the PF, refers to children up to the age of 18 years e.g. “Any death of a child or young person under the age of eighteen years who is ‘looked after’ by a local authority..... should be reported to the Procurator Fiscal”.

Regarding infectious diseases, it is only those deaths which pose an acute and serious public health risk that require to be reported, **not all notifiable infectious deaths** *per se*. This may include deaths which are "sudden" or those which could cause "public anxiety" as in the [PF guidance](#)¹⁰.

Community Health Index (CHI) number and the Health Board where death occurred also need to be included the form while reporting a death to the PF.

5. SEQUENCE LEADING TO DEATH, UNDERLYING CAUSE OF DEATH AND CONTRIBUTORY CAUSES (PART C)

The MCCD is set out in 2 parts. You are asked to start with the immediate, direct cause of death on line I(a), then to go back through the sequence of events or conditions that led to death on subsequent lines, until you reach the one that started the fatal sequence.

Usually, if the certificate has been completed properly, the condition on the lowest completed line of part I will have caused all of the conditions on the lines above it. However, sometimes what is written on the lowest completed line will have created the circumstances for (rather than caused) the other conditions. For example, if someone had a fall, went to hospital, contracted a healthcare associated infection and died, one would say that the accident initiated the train of morbid events leading to death (even though the fall *per se* did not cause the infection).

¹⁰<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

This initiating condition, on the lowest line of part I, will usually be selected as the **underlying cause of death**. WHO defines the *underlying cause of death* as “**a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury**”. From a public health point of view, preventing this first disease or injury will result in a greater health gain than treating a subsequent direct/immediate cause of death.

The causes of death should be described succinctly i.e. naming relevant diseases, conditions or events which can be coded by NRS using International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD10) codes, without additional narrative. Avoid long lists on the same line: for example, you should use a separate line for each condition and avoid recording both a cause and its consequence on the same line. Rarely, 2 conditions can be given on the same line if it impossible to say which was the main cause of the condition mentioned in the line above (see section 5.2 below). The “approximate interval” boxes should indicate time intervals, rather than relative time intervals such as “x” days earlier/afterwards than the condition mentioned in the line above or below. Importantly, write legibly and avoid abbreviations (See section 5.8).

Examples of cause of death section from MCCDs:

Cause of death - *the disease or condition that you believe to be the underlying cause should appear in the lowest completed line of part I*

Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health service and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

You should also enter any other diseases, injuries, conditions, or events that you believe contributed to the death, but were not part of the direct sequence, in part II of

the certificate. Something “contributed to” the death if it made the person more vulnerable to the fatal condition, or weakened the person so that death occurred sooner than otherwise would have been the case. For example, someone with diabetes mellitus who died of lung cancer might have died sooner than would have been the case if he/she did not have diabetes mellitus. If so, diabetes mellitus should be recorded in Part II as contributing to death.

However, do not enter any diseases, injuries, conditions or events that did not, in your view, contribute to the death. For example, if someone with osteoarthritis died of lung cancer, it is unlikely that osteoarthritis would have contributed in any way to death, so it should not be mentioned in part II.

Where appropriate, in parts I or II, you should give information about clinical interventions, procedures or drugs that may have led to adverse events.

It is important to record, in the boxes on the right-hand side of the form, the approximate interval between the onset of each disease, injury, condition or event and death. This information provides confirmation that the entries are in the correct order, and may be essential for the accurate classification of the causes of death. Ticking the box, without the specified time intervals, will not be acceptable.

Example:

I		Approximate interval between onset and death		
		Years	Months	Days
Disease or condition directly leading to death	(a) Intraperitoneal haemorrhage			1
Antecedent causes Morbid conditions, if any, giving rise to the	due to (or a consequence of) (b) Ruptured metastatic deposit in liver			1
	due to (or a consequence of) (c) Metastatic deposit in liver		6	
	due to (or a consequence of)	2		

above cause, stating the underlying condition last	(d) Primary adenocarcinoma of ascending colon			

II Other significant conditions contributing to the death, but not related to the disease or condition causing it	Type 2 (Non-insulin dependent) diabetes mellitus	20		

The colon cancer on line 1(d) led directly to the liver metastases on line 1(c), which ruptured after 6 months on line 1(b), causing the fatal haemorrhage on 1(a). Adenocarcinoma of the colon is the underlying cause of death. Non-insulin dependent type 2 diabetes contributed to the death but was not the direct cause of death.

Example:

I		Approximate interval between onset and death		
		Years	Months	Days
Disease or condition directly leading to death	(a) Cerebral infarction			1
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	due to (or a consequence of) (b) Thrombosis of basilar artery			2
	due to (or a consequence of) (c) Cerebrovascular atherosclerosis		6	
	due to (or a consequence of) (d)			

II Other significant conditions contributing to the death, but not related to the disease or condition causing it				

In subsequent examples, to save space, the layout of the MCCD has not been reproduced and the information about the interval between onset and death is not shown.

In some cases, a single disease may be wholly responsible for the death. In this case, it should be entered on line I(a) and the rest of parts I and II can be left blank.

Example:

Ia. Meningococcal septicaemia

Meningococcal septicaemia is the underlying cause of death.

5.1 More than 4 conditions in the sequence

The MCCD has 4 lines in part I for the sequence leading directly to death. If you want to include more than 4 steps in the sequence, you can do so by writing more than one condition on a line, indicating clearly that one is due to the next.

Example:

Ia. Post-transplant lymphoma

Ib. Immunosuppression

Ic. Renal transplant

Id. Glomerulonephrosis due to insulin dependent Type 2 diabetes mellitus

II. Recurrent urinary tract infections

Insulin dependent Type 2 diabetes with renal complications is the underlying cause.

5.2 More than one disease may have led to death

If you know that your patient had more than one disease or condition that was compatible with the way in which he or she died, but you cannot say which was the most likely cause of death, you should include them all on the certificate. They should be written on the same line and you can indicate that you think they contributed equally by writing “joint causes of death” in brackets.

Example:

Ia. Cardiorespiratory failure

Ib. Ischaemic heart disease and chronic obstructive airways disease (joint causes of death)

II. Osteoarthritis

Example:

Ia. Hepatic failure

Ib. Liver cirrhosis

Ic. Chronic hepatitis C infection and alcoholism (joint causes of death)

Where more than one condition is given on the lowest used line of part 1, NRS will use the internationally agreed mortality coding rules in ICD10 to select the underlying cause for routine mortality statistics. This will normally be the first cause that is mentioned on the lowest used line of part I. Therefore, in the example above, “Chronic hepatitis C” infection will be selected as the underlying cause of death for the purpose of producing statistics.

This is particularly important if a death was caused *by a mixture of natural and other causes*. For example, a death due to “chronic drug abuse and atherosclerotic cardiovascular disease” *will be counted in the statistics as drug-related*, whereas if the cause was given as “atherosclerotic cardiovascular disease and chronic drug abuse”, *it will be counted as due to natural cause*. Therefore, if you are unsure

which condition caused the death, but have a slight suspicion as to what the main one was, put it at the start of the line.

NRS codes all conditions mentioned on the certificate. Multiple cause of death data are used in a variety of ad hoc analyses, and can be made available for research in some circumstances. Multiple cause data provide useful additional information on the mortality burden associated with diseases that are not often selected as the main cause of death. For example, conditions that are very often complications of another disease or its treatment, such as *deep vein thrombosis/pulmonary embolism or healthcare associated infections* should rarely be the underlying cause of death. Their contribution to mortality is better estimated from multiple cause data. You must tick the box “PM1” if information from a post mortem examination is included in the MCCD.

In contrast to the above, **if you do not know that your patient actually had any specific disease compatible with the mode and circumstances of death**, you must consider whether the death requires to be reported to the PF, in accordance with the [PF guidance](#)¹¹. For example, if your patient died after the sudden onset of chest pain that lasted several hours and you have no way of knowing whether he or she may have had a myocardial infarct, a pulmonary embolus, a thoracic aortic dissection, or another pathology, which caused the chest pain, and to the best of your knowledge and belief you cannot accurately complete the MCCD, then it may be that in such circumstances, and in the absence of a hospital post mortem examination, the death will require to be reported to the PF to ensure that the cause of death is determined. Consent from the next of kin/legal guardian/executor of the deceased’s estate is required for hospital post mortem autopsies.

5.3 Results of investigations awaited

If in broad terms you know the disease that caused your patient’s death, but you are awaiting the results of laboratory investigation for further detail, you need not delay completing the MCCD. For example, a death can be certified as bacterial meningitis

¹¹<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

once the diagnosis is firmly established, even though the organism may not yet have been identified. Similarly, a death from cancer can be certified as such while still awaiting detailed histopathology. This allows the family to register the death and arrange the funeral. However, you should indicate clearly on the MCCD that information from investigations might be available later. You can do this by ticking “PM2” on the MCCD for post-mortem (autopsy) information, or by ticking the “extra information for statistical purposes “box X” on the certificate for results of investigations initiated ante-mortem. It is important for public health surveillance to have this information on a national basis, for example, to know how many meningitis and septicaemia deaths are due to meningococcus, or to other bacterial infections. NRS will write to the certifying doctor whether a General Practitioner (GP), or for hospital deaths, the Consultant in charge of the patient’s care, requesting further details of any other information which might help to make the cause of death clearer. **NRS will use such information for statistical purposes. The MCCD or the Form 14 will not normally be changed on the basis of further information gained from these enquiries.**

Section 9 describes what you should do if you wish to change the public record of the cause of death.

It is important that you respond to any request from NRS for additional information to enable the death to be counted correctly in statistics, which are used to develop public health policies. Health practitioners and researchers need such statistics based on complete and accurate information about the cause of death in order to understand the scale of various health problems and develop effective interventions to improve the health of the population.

If a certificate is issued prior to completion of histological or toxicological cases, for example in deaths due to misuse of substances, the wording “unascertained pending test results” may be used in line I(a) by Forensic Pathologists. Forensic Pathologists and the doctor/s who were involved in the management of the deceased prior to death will be asked by NRS to provide more detail later. Please do so even if the death has been or is being investigated by the PF.

5.4 Avoid “old age” alone

“Old age” or “frailty due to old age” should only be given as the **sole** cause of death when all of the following criteria have been met.

These are:-

- You have personally cared for the deceased over a long period (years, or many months)
- You have observed a gradual decline in your patient's general health and functioning
- You are not aware of any identifiable disease or injury that contributed to the death
- You are certain that there is no other reason that the death should be reported to the PF
- The patient is 80 years or older and all the condition listed above are met

You should bear in mind that the PFs, NRS, and organisations that regulate standards in health and social care, may ask you to support your statement with information from the relevant medical records of the deceased and any investigations that might have a bearing on the cause of death.

You should also be aware that the deceased’s family may not regard old age as an adequate explanation for their relative’s death and may request an “Interested Person” review by the MR, which will be a Level 2 review, or further investigation by the appropriate authorities.

It is unlikely that patients would be admitted to an acute hospital if they had no apparent disease or injury. It follows, therefore, that deaths in acute hospitals are unlikely to fulfil the conditions above. You can specify old age as the underlying cause of death, but you should also mention in part I or part II, as appropriate, any medical or surgical conditions that may have contributed to the death.

Example:

Ia. Pathological fractures of femoral neck and thoracic vertebrae

Ib. Severe osteoporosis

Ic. Old age

II. Fibrosing alveolitis

Example:

Ia. Old age

II. Non-insulin dependent Type 2 diabetes mellitus, essential hypertension and diverticular disease

Example:

Ia. Hypostatic pneumonia

Ib. Dementia

Ic. Old age

5.5 Never use “natural causes” alone

The term “natural causes” alone, with no specification of any disease on an MCCD, is not sufficient to allow the death to be registered. If you do not have the necessary information to state to the best of your knowledge and belief what disease caused your patient’s death, then in the absence of a post mortem examination, it is unlikely that you can accurately complete the MCCD. It may be that, in such circumstances, the death will require to be reported to the PF to ensure that the cause of death is determined. The PF is not medically trained, does not adjudicate on what causes of death are medically acceptable, and does not certify deaths.

As explained in Section 3, following the implementation of the Certification of Death (Scotland) Act 2011, MRs can be a source of advice.

5.6 Avoid organ failure alone

Do not certify deaths as due to the failure of any organ or “multi-organ failure”, without specifying the disease or condition that led to the organ failure. If you suspect that the organ failure may have been due to unnatural causes, such as accidental or deliberate poisoning, injury or industrial disease; other circumstances which may require the death to be reported to the PF, then these should be reported to the PF.

Example:

Ia. Renal failure

Ib. Necrotising proliferative nephropathy

Ic. Systemic lupus erythematosus

II. Raynaud's phenomenon and vasculitis

Example:

Ia. Liver failure

Ib. Hepatocellular carcinoma

Ic. Chronic hepatitis B infection

Example:

Ia. Congestive cardiac failure

Ib. Essential hypertension

Conditions such as renal failure may come to medical attention for the first time in frail, elderly patients in whom vigorous investigation and treatment may be contraindicated, even though the cause is not known. When such a patient dies, if you do not have the necessary information to state to the best of your knowledge and belief what disease caused your patient's death, then, without a post mortem examination, it is unlikely that you can complete the MCCD. It may be that, in such

circumstances, the death will require to be reported to the PF to ensure that the cause of death is determined.

5.7 Avoid terminal events, modes of dying and other vague terms

Terms that do not identify a disease or pathological process clearly are not acceptable as the only cause of death. This includes terminal events, or modes of dying such as cardiac or respiratory arrest, syncope or shock. Very vague statements such as cardiovascular event or incident, debility or frailty are equally unacceptable. “Cardiovascular event” could be intended to mean a stroke or myocardial infarction. It could, however, also include cardiac arrest or fainting, or a surgical or radiological procedure. If no clear disease can be identified as the cause of death, to the best of your knowledge or belief, and in the absence of a post mortem examination, then it is unlikely that you can accurately complete the MCCD. It may be that, in such circumstances, the death will require to be reported to the PF to ensure that the cause of death is determined.

5.8 Never use abbreviations or symbols

Do not use abbreviations on MCCDs. Their meaning may seem obvious to you in the context of your patient and their medical history, but it may not be clear to others and therefore may be a source of ambiguity and cause of potential delay to the registration process. For example, does a death from “MI” refer to myocardial infarction or mitral incompetence? Is “RTI” a respiratory or reproductive tract infection, or a road traffic incident? The registrar **cannot accept a certificate that includes abbreviations.** (The only exceptions, which the registrar can accept, are HIV and AIDS for human immunodeficiency virus infection and acquired immune deficiency syndrome). You, or the GP, or the Consultant in charge of the care of the deceased, as appropriate, may be required to complete a new certificate with the conditions written out in full, before the death can be registered. This is inconvenient for you and for the family of the deceased. **The same applies to medical symbols such as Rx, Tx, Dx, +ve, #, ?, etc. Use words such as “probably” or “presumably” if uncertain. Please write legibly if providing a hand written MCCD.**

5.9 Perinatal deaths

It is important to parents to state the name of the infant on the MCCD, and you must make all reasonable efforts to include a name acceptable to the parents. Some parents may not name their children immediately and may agree an alternative.

CHI numbers will not be provided specifically for registration of deaths e.g. a 23 week pregnant woman delivers early and the baby unfortunately survives for a very short time e.g. a few minutes or a few hours. The registrar will accept the MCCD in this case without the CHI number.

Perinatal deaths are manually scrutinised by the coders in NRS. Maternal codes are not used for the neonates and if the software used applies a maternal ICD code, this will be manually changed by NRS. However, it is important to record the relevant maternal conditions on the MCCD, although these will not be coded as the underlying cause of death. The maternal information is useful as it can be used in a variety of analyses and for research. It is important to note that while other countries may use a separate and different MCCD for perinatal deaths, this is not the case in Scotland.

Example:

Ia. Pulmonary hypoplasia

Ib. Extreme prematurity

Ic. Fetus affected by premature rupture of membranes

6. SPECIFIC CAUSES OF DEATH

6.1 Stroke and cerebrovascular disorders

Give as much detail about the nature and site of the lesion as is available to you. For example, specify whether the cause was haemorrhage, thrombosis or embolism, and the specific artery involved, if known. Remember to include any antecedent

conditions or treatments, such as atrial fibrillation, artificial heart valves, or anticoagulants that may have led to cerebral emboli or haemorrhage.

Avoid the term “cerebrovascular accident” and consider using terms such as “ischaemic stroke” or “cerebral infarction” if no more specific description can be given.

Example:

Ia. Subarachnoid haemorrhage

Ib. Ruptured aneurysm of anterior communicating artery

Example:

Ia. Intraventricular haemorrhage

Ib. Warfarin anticoagulation

Ic. Atrial fibrillation

6.2 Neoplasms

Malignant neoplasms (cancers) remain a major cause of death. Accurate statistics are important for planning care and assessing the effects of changes in policy or practice. You should indicate whether a neoplasm was benign, malignant, or of uncertain behaviour. Please remember to specify the histological type and anatomical site of the cancer.

Example:

Ia. Carcinomatosis

Ib. Small cell carcinoma of left main bronchus

Ic. Heavy smoker

II. Hypertension, cerebral arteriosclerosis, ischaemic heart disease.

You should make sure that there is no ambiguity about the primary site if both primary and secondary cancer sites are mentioned. Do not use the terms “metastatic” or “metastases” unless you specify whether you mean metastasis to, or metastasis from, the named site.

Example:

Ia. Intraoperative haemorrhage

Ib. Metastases in liver

Ic. From primary adenocarcinoma of ascending colon

II. Non-insulin dependent Type 2 diabetes mellitus

Example:

Ia. Pathological fractures of left shoulder, spine and shaft of right femur

Ib. Widespread skeletal secondaries

Ic. From Primary adenocarcinoma of breast

II. Hypercalcaemia

Example:

Ia. Lung metastases

Ib. From testicular teratoma

If you mention 2 sites that are independent primary malignant neoplasms, make that clear.

Example:

Ia. Massive haemoptysis

Ib. Primary small cell carcinoma of left main bronchus

II. Primary adenocarcinoma of prostate

If a patient has widespread metastases, but the primary site could not be determined, you should state this clearly

Example:

Ia. Multiple organ failure

Ib. Poorly differentiated metastases throughout abdominal cavity

Ic. Unknown primary site

If you do not yet know the cancer type and are expecting the result of histopathology, indicate that this information may be available later by ticking the “extra information for statistical purposes box X” on the certificate for results of investigations initiated ante-mortem.

You, or the GP, or the Consultant in charge for the deceased’s care, as appropriate, will be sent a letter requesting this information at a later date.

In the case of leukaemia, specify whether it is acute, sub-acute or chronic, and the cell type involved.

Example:

Ia. Neutropenic sepsis

Ib. Acute myeloid leukaemia

Example:

Ia. Haemorrhagic gastritis

Ib. Chronic lymphatic leukaemia

II. Myocardial ischaemia, valvular heart disease

6.3 Diabetes Mellitus

Always remember to specify the type of diabetes, such as whether your patient's diabetes was Type 1 or Type 2, and insulin dependent or non-insulin dependent. If diabetes is the underlying cause of death, specify any complication or consequence that led to death, such as ketoacidosis.

Example:

Ia. End-stage renal failure

Ib. Diabetic nephropathy

Ic. Insulin dependent Type 1 diabetes mellitus

Example:

Ia. Septicaemia – non-resistant Staphylococcus aureus

Ib. Gangrene of both feet due to peripheral vascular disease

Ic. Non-insulin dependent Type 2 diabetes mellitus

II. Ischaemic heart disease

6.4 Deaths involving infections and communicable diseases

Mortality data is important in the surveillance of infectious diseases, as well as monitoring the effectiveness of immunisation and other prevention programmes. If you have a reasonable suspicion that the deceased person had a notifiable disease, either as a cause of death or not, you have a statutory duty to notify the local Health Board (in practice the local Health Protection Team within the Public Health Department), unless the case has already been notified. If you are in any doubt about whether a case is notifiable, you should contact your local Health Protection Team for advice. The list of notifiable diseases is contained in [Schedule 1, part 1 of the Public Health etc. \(Scotland\) Act 2008](#)¹².

¹² http://www.legislation.gov.uk/asp/2008/5/pdfs/asp_20080005_en.pdf

The Health Protection Team will also wish to ensure that those handling the body know the nature of any risk to public health and any precautions which should be taken, as this is a statutory duty placed on the Health Board.

The GMC Guidance on Confidentiality (most recent edition of September 2009) makes it clear that if a serious communicable disease has contributed to the cause of death, doctors must record this on the MCCD. The guidance for doctors on [Good Medical Practice](#)¹³ (paragraph 71) reminds doctors of their duty to be honest and trustworthy when completing or signing forms and their legal duty to complete MCCDs honestly and fully including for serious communicable diseases.

Further information is available in section 7.6 – Hazards.

In deaths from infectious disease, you should state the manifestation or body site, e.g. pneumonia, pyelonephritis, hepatitis, meningitis, septicaemia, or wound infection. You should also specify if known:

- The infecting organism, e.g. *pneumococcus*, *influenza A virus*, *meningococcus*
- Antibiotic resistance, if relevant, e.g. *meticillin resistant Staphylococcus aureus (MRSA)*, or *multiple drug resistant Mycobacterium tuberculosis*
- The source and/or route of infection, if known, e.g. *food poisoning*, *needle sharing*, *contaminated blood products*, *post-operative*, *community or hospital acquired*, or *health care associated infection*.

Example:

1a. Bilateral pneumothoraces

1b. Multiple bronchopulmonary fistulae

1c. Extensive, cavitating pulmonary tuberculosis (smear and culture positive)

¹³ http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0414.pdf

II. Iron deficiency anaemia; ventilator associated pseudomonas pneumonia

You need not delay completing the certificate until laboratory results are available, provided you are satisfied that the death is not one in which the circumstances require to be reported to the PF. You should indicate, by ticking “extra information available for statistical purposes box X” on the certificate for results of investigations initiated ante-mortem, that further information may be available later. A letter will then be sent to you, or the GP, or to the Consultant in charge of the care of the deceased, as appropriate, requesting this information. The coded cause of death will be amended for statistical purposes.

Remember to specify any underlying disease that may have suppressed the patient's immunity or made them more susceptible to the infection that led to the death.

6.4.1 Healthcare Associated Infections (HAI)

It is a matter for your clinical judgment, whether a condition the patient had contributed to their death, and therefore, should be included on the MCCD. While families may be surprised if you do not include something that they believe contributed to their relative's death, it is your clinical judgment that must be recorded.

Where infection does follow treatment, including surgery, radiotherapy, antineoplastic, immunosuppressive, antibiotic or other drug treatment for another disease, remember to specify the treatment and the disease for which it was given.

If a Healthcare Associated Infection (HAI) was part of the sequence leading directly to death, it should be in part I of the certificate, and you should include all the conditions in the sequence of events back to the original disease being treated.

It is important to emphasise that it is only HAI deaths, which pose an acute and serious public health risk, must be reported to the PF, as described in the [PF guidance](#)¹⁴.

¹⁴<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

Reporting of an HAI related death will not necessarily lead to further investigation of the cause of death by the PF. It may be that following discussion with you, the PF will be content with the terms of the MCCD that you propose. Identification and investigation of any clusters of HAI related deaths that may imply an acute and serious public health risk will be through the monitoring undertaken by Health Boards, supported by Health Protection Scotland (HPS), NRS and Information Services Division (ISD) of NHS National Services Scotland.

Example:

1a. Clostridium difficile pseudomembranous colitis

1b. Multiple antibiotic therapy

1c. Community acquired pneumonia with severe sepsis

II Immobility, Polymyalgia Rheumatica, Osteoporosis

Example:

1a. Bronchopneumonia (hospital acquired meticillin resistant Staphylococcus aureus)

1b. Multiple myeloma

II Chronic obstructive airways disease

If your patient had an HAI which was not part of the direct sequence of events leading to death, but which you think contributed to their death, it should be mentioned in part II.

Example:

1a. Carcinomatosis and renal failure

1b. Adenocarcinoma of the prostate

II. Chronic obstructive airways disease and catheter associated Escherichia coli urinary tract infection

6.4.2 Pneumonia

Pneumonia may present in previously fit adults, but often it occurs as a complication of another disease, such as those affecting the lungs, mobility, immunity, or swallowing. Pneumonia may also follow other infections and may be associated with treatment for disease, injury or poisoning, especially when ventilatory assistance is required. Remember to specify, where possible, whether it was lobar or bronchopneumonia and whether primarily hypostatic, or related to aspiration and the organism involved. You should include the whole sequence of conditions and events leading up to it. If known, specify whether the pneumonia was hospital or community acquired. If it was associated with mechanical ventilation, or invasive treatment, this should be clearly stated.

Example:

Ia. Lobar pneumococcal pneumonia

Ib. Influenza A

II. Ischaemic heart disease

For many years, bronchopneumonia was given as the immediate cause of death on a large proportion of certificates. This may have reflected common terminal chest signs and symptoms, rather than significant infection in many cases. The proportion of certificates that mention bronchopneumonia has been steadily falling for 20 years. If you do report bronchopneumonia, remember to include, in the sequence in part I, any predisposing conditions, especially those that may have led to paralysis, immobility, depressed immunity or wasting, as well as chronic respiratory conditions such as chronic bronchitis.

Example:

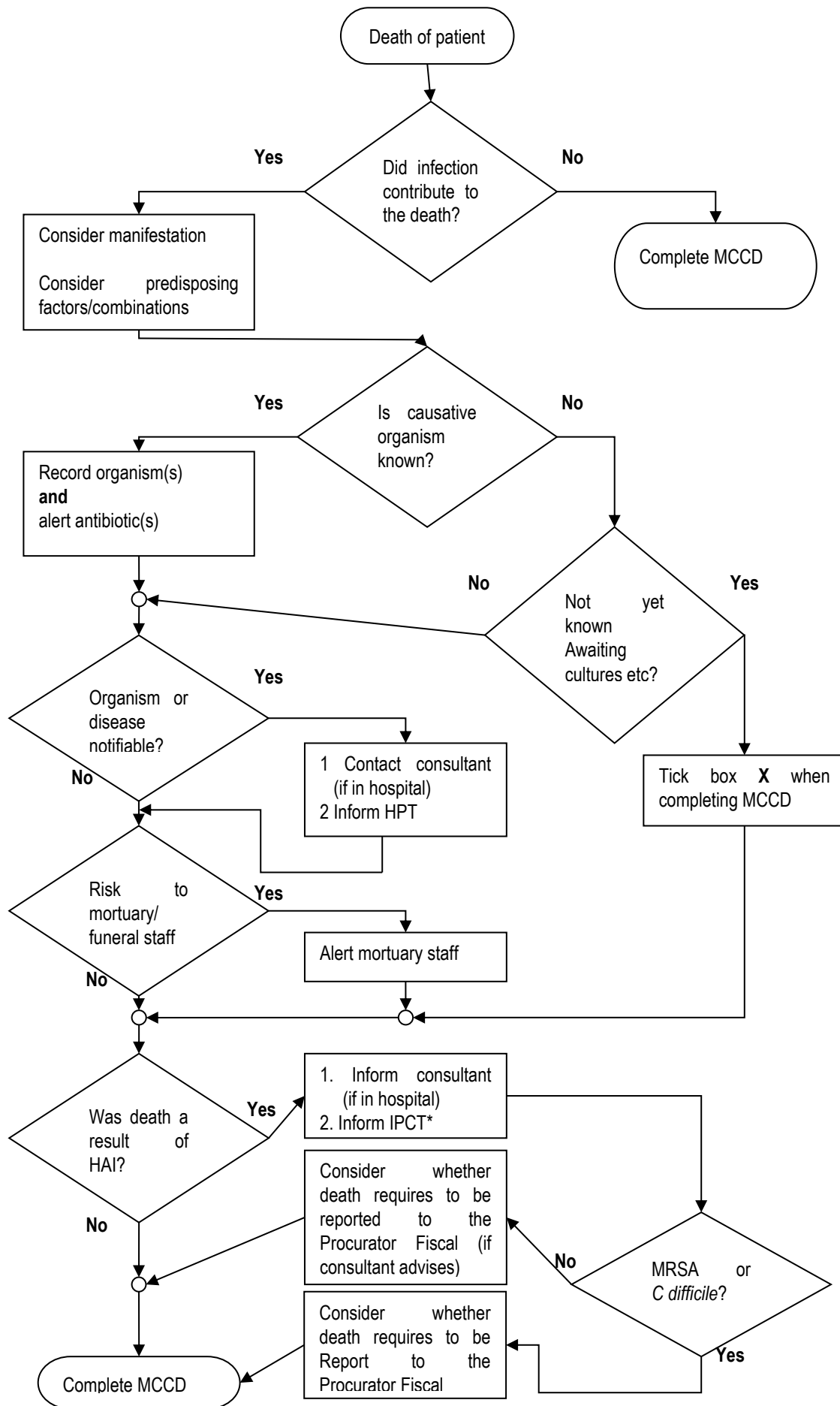
Ia. Bronchopneumonia

Ib. Immobility and wasting

Ic Alzheimer's disease

6.4.3 Healthcare Associated Infection (HAI) flow chart

The definition of what constitutes a HAI can be difficult. HAI includes meticillin resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile infections, but it can include other infections. The flow chart for hospital staff below may help and you can obtain further information from the Health Protection Teams (HPT) in your Health Boards, including Infection Control Doctors (ICD).



6.5 Injuries and external causes

Any death where there is evidence or suspicion of homicide must be reported to the PF. Similarly any death where the circumstances raise the possibility of suicide ought to be reported to the PF in accordance with the [PF guidance](#)¹⁵. For example, a certifying doctor who is of the view that external injuries on a deceased or poisoning of the deceased has contributed to the death, should consider whether the death requires to be reported to the PF. Not all injuries are reportable to the PF. For example, if the deceased patient has a cut on their left leg, but otherwise presented with a cardiac problem and relevant history, and subsequently died of cardiac failure, then the presence of the external leg injury would not of itself require the death to be reported to the PF.

Full details of how the injury occurred should be recorded in the deceased patient's clinical records. This should include the place where it is said to have happened, such as home (address specified), in the street (street name), or at work (work address). A full note of any discussions with the PF should be recorded in the deceased's clinical records.

Example:

Ia. Pulmonary embolism

Ib. Hemiarthroplasty

Ic. Fractured neck of femur

Id. Tripped on loose floor rug at home

II. Left sided weakness and difficulty with balance since haemorrhagic stroke

Remember to state clearly if a fracture was pathological, i.e. due to an underlying disease process such as a metastasis from a malignant neoplasm or osteoporosis.

¹⁵<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

When causes of death such as self-neglect or self-injury are due to psychiatric illness, the psychiatric illness should be mentioned as a contributory factor or underlying cause of death as appropriate.

6.6 Substance misuse

Deaths from diseases related to chronic alcohol or tobacco use of themselves do not need to be reported to the PF, provided the disease is clearly stated on the MCCD.

Example:

Ia. Carcinomatosis

Ib. Bronchogenic carcinoma upper lobe left lung

Ic. Heavy smoker

II. Chronic bronchitis and ischaemic heart disease.

Example:

Ia Hepatic encephalopathy

Ib Alcoholic liver cirrhosis

II Poorly controlled insulin dependent Type 2 diabetes mellitus

Deaths which are due to **acute or chronic poisoning, by any substance, and drug related deaths involving dependence or misuse of substances other than alcohol and tobacco** should be reported to the PF, as these types of deaths have the potential to be suicides or criminal/homicidal in nature.

7. OTHER AREAS IN the MCCD (FORM 11 or F(11))

PART A – DETAILS OF THE DECEASED

7.1 Date and time of death

You should record the date and time of death as accurately as possible. This may be required for legal or religious reasons. If a person such as a nurse, relative or a carer was present when the person died, you may record reliable information that they give you about the date and time of death. Otherwise, please give your best estimate based on all the information available to you. **Do not use the time of your attendance or when you pronounce life extinct, unless you were present at the time of death.** Please only enter one time and date of death. In exceptional circumstances, a range in which death is likely to have occurred may be provided in the free text box by Forensic Pathologists e.g. around one year, or 3 to 4 weeks.

You must ensure that the correct date of death is recorded in the MCCD when you certify a death which occurred before midnight, but you complete the certificate the following day.

7.2 Place of death

You should record, to the best of your knowledge, exactly where the person died (for example - hospital, care home, private house, own home, etc., along with the relevant address, including postcode). If the person did not die in a place that can be readily identified by an address and description as above, give the location (for example, a particular stretch of motorway or a specific area of countryside), avoiding abbreviations which can be misinterpreted.

7.3 CHI (Community Health Index) number

You should record the CHI number in the MCCD, or in the documents when reporting a death to the PF. Do not use the NHS number or any other number such as the hospital number. Most patients residing in Scotland will have a CHI number.

This is a 10 digit number commencing with 6 digits of the date of birth followed by further 4 digits which distinguish between people with the same date of birth – it is the entire 10 digits which make up the CHI number.

Registrars are aware that the CHI number may not be available in some infrequent and specific circumstances such as still births; people not resident in Scotland (e.g. holidaymakers from overseas or other parts of the United Kingdom, and other temporary residents); and infants, including those less than 24 weeks gestation, who live for a short time after birth.

It is important that CHI numbers are **not** created solely for the purposes of death registration as the creation of a CHI record may lead to other health service actions and has risks (e.g. deceased patients may be called for NHS screening programmes).

7.4 Maternal death (M1 and M2)

You should consider if the deceased could have been pregnant within the year before she died and tick box M1 or M2 as appropriate, regardless of the cause of death. This is to ensure that there is complete recording of maternal deaths nationally, and that pregnancy is always considered as a possible cause of death.

7.5 Signature of doctor and consultant's name (PART B)

You must sign the certificate, include your GMC reference number (also known as the GMC registration number), and add the date. You should also **print your name clearly in BLOCK CAPITAL LETTERS**. You may use a stamp with your business address if available and if it is practical to use. You should not use your domestic or personal address or telephone number/s, but record the address of the place of your work, (such as a hospital or General Practice), and business telephone number. You must give a business telephone number, which is also available through your place of work (e.g. via the hospital switchboard). If the patient died in hospital, you should also include the ward or the department where the patient died, and the Consultant in charge of the patient.

7.6 Hazards (PART D – DH1, DH2, DH3)

While reporting information related to “hazards”, some of the principles that you should consider are that:

- The extract from the register of deaths or the Certificate of the Registration of Death (Form 14) is a publically-available document. It includes your description of the cause of death and the information about “hazards” (Parts C and D of the MCCD in Annex 1). The MCCD itself (Form 11) is **not** publically-available the MCCD: it is covered by patient confidentiality and is destroyed by the registrars after 3 years retention by them.
- The Data Protection Act does not apply to people who are deceased, but information disclosure is governed by the [Access to Health Records Act 1990](#)¹⁶ e.g. the duty of confidentiality remains after a patient has died and the personal representative of the deceased and people who may have a claim arising from the patient’s death are permitted access to the records. In addition, GMC provides guidance on disclosure of the records of the deceased (paragraphs 70-72 [GMC Guidance on Confidentiality](#)¹⁷) e.g. GMC advises that doctors have a duty of confidentiality to patients who are deceased. However the duty of confidentiality is not absolute. Personal information can be disclosed in certain circumstances such as: if it is “required by law; the patient consents – either implicitly for the sake of their own care or expressly for other purposes; and/or it is justified in the public interest” (paragraph 8 of the GMC Guidance on Confidentiality). Consent can only be given on behalf of the deceased by the next of kin/legal guardian/executor of the deceased’s estate.

[NHSScotland Guidance on Patient Confidentiality](#)¹⁸ also provides guidance to healthcare professionals working in NHSScotland.

- The funeral directors and others have a duty of care to their staff and their customers (e.g. those who physically come into contact with the body). It is a criminal offence (which carries a custodial sentence) under the Health and Safety legislation if someone becomes infected or injured through failure of

¹⁶ <http://www.legislation.gov.uk/ukpga/1990/23/section/3>

¹⁷ http://www.gmc-uk.org/static/documents/content/Confidentiality_-_English_0414.pdf

¹⁸ <http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4011563/Revised%20Code%20of%20Confidentiality%20-%20Final.pdf>

appropriate action by relevant people. The National Association of Funeral Directors (NAFD) is of the opinion that, in the event of an accidental contamination, it is highly unlikely that a funeral director being told verbally of the presence or absence of a particular risk by the family or the mortuary staff at the hospital will be viewed as sufficient or robust evidence of the presence or absence of a hazard by the Health and Safety Executive (HSE). Further information is available from the [HSE guidance](#)¹⁹.

- Regarding Notifiable diseases, [Guidance on Part 2 - Notifiable Diseases, Notifiable Organisms and Health Risk States](#)²⁰ of The Public Health etc. (Scotland) Act 2008 lists the diseases, organisms and health risk states which are to be notified by a medical practitioner, and can be accessed through the guidance attached link below. A health risk state is categorised as infectious, a result of contamination (e.g. with radioactive material), or the result of a toxin or poison to which others may be exposed. Please note the advice in the guidance that if you have any doubts about whether to notify a condition, on the grounds of its seriousness or potential to affect others, you should discuss the condition with the local Health Protection Team or another senior colleague. The Notifiable diseases and organisms include several blood borne viruses.

You are required to tick the relevant sections in boxes DH1, DH2 and DH3 on the MCCD confirming the existence or absence of any potentially hazardous implants to the best of your knowledge and belief. You should not provide the details of the hazards on the MCCD.

Based on guidance and legislation as explained in the principles above, when disclosing detailed information of the hazard to relevant person/s, you will need to make decisions on a case by case basis, taking account of the context, the views of others where appropriate, and using your clinical judgement.

¹⁹ <http://www.hse.gov.uk/pubns/web01.pdf>

²⁰ <http://www.scotland.gov.uk/Topics/Health/Policy/Public-Health-Act/Implementation/Guidance/Guidance-Part2>

The funeral directors and burial and cremation authorities will have access to Form 14 which will contain the information from Part D of the Form 11 regarding hazards.

The body may pose a risk to people who come into close contact with it such as embalmers, or next of kin who lay out the body for the funeral, or others who come into close contact with the body, (e.g. an air borne communicable disease, such as Pulmonary TB; blood borne such as hepatitis C; the result of exposure and presence of radioactive material; and the result of a toxin or poison to which others may be exposed).

It is also important to confirm whether the deceased person has had an implant fitted in life as some implants may cause damage to the cremator, and may even be a serious health and safety risk to the people in the vicinity of the cremator, (e.g. if they explode during the process of cremation). A current list (this may change in the future), of potentially dangerous implants is included below:

Battery powered and other implants that could cause problems during cremation include:

- Pacemakers
- Implantable Cardioverter Defibrillators (ICDs)
- Cardiac resynchronization therapy devices (CRTDs)
- Implantable loop recorders
- Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices (BiVADs)
- Implantable drug pumps including intrathecal pumps
- Neurostimulators (including for pain & Functional Electrical Stimulation)
- Bone growth stimulators
- Hydrocephalus programmable shunts
- Any other battery powered implant
- Fixion nails

- Brachytherapy to the prostate, i.e. radioactive iodine-125 seeds (advice from the ISBN 978 903613 49 8, UK Guidance on Radiation Protection Issues following permanent Iodine-125 Seed Prostate Brachytherapy Report 106, states that cremation can be carried out normally after 20 months have elapsed since the seeds were implanted, based on a 145Gy permanent seed implant in the prostate and 25% residual activity remaining in the remains after the cremation process). Cremation is not recommended until 20 months after the seeds were implanted and scattering of ashes is not recommended until 22 months after the seeds were implanted, with the ashes strewn over an area of not less than one square mile.

Dental mercury amalgam is not required to be removed from a deceased person prior to cremation as environmental legislation requires that crematoria abate (filter) mercury emissions from 50% of cremations. Dental amalgam therefore is not required to be recorded as an implant.

If you require more information about implants, it can be accessed through the link below (particularly Annex A).

<http://www.justice.gov.uk/downloads/burials-and-coroners/cremations/cremation-applicants-guidance.pdf>²¹.

To prevent further distress to the bereaved, you should respond promptly to any reasonable queries from the crematoria, to the best of your knowledge and belief.

COPFS expects you to report only those infectious deaths which pose an acute and serious public health risk, not all cases.

7.7 Stillbirth

The Stillbirth Register is separate from the Register of Births and the Register of Deaths and is not covered by the new medical review system.

²¹<http://www.justice.gov.uk/downloads/burials-and-coroners/cremations/cremation-applicants-guidance.pdf>

A still birth certificate can be signed by you or the midwife who has attended the delivery. The still birth should be registered within 21 days of the delivery. If no one attended the delivery, the case must be discussed with the PF and reported to the PF if required. The certificate of still birth (Form 6 in Annex 1) and certification of registration of stillbirth (Form 8 in Annex 1) is due to be revised and you will be informed when this happens.

Fetuses born dead before 24 weeks are not registered as stillbirths. In this instance, there are no statutory forms currently required to be completed, and the family do not have to register the death with the registrar. This includes a fetus which was delivered after 24 weeks but which was dead in utero before 24 weeks. However, in the future, there may be a requirement to complete statutory forms for “non-viable” fetuses born before 24 weeks and who do not show any signs of life.

A baby who has shown signs of life after birth is considered live-born for registration purposes, irrespective of the number of weeks of the duration of the pregnancy. In these cases you must complete an MCCD (see section 5.9 regarding Neonates), or discuss the death with the PF, if the circumstances of the death are appropriate as in the [PF guidance](#)²².

8. REPLACEMENT MCCDS

Replacement MCCD should be provided only in **exceptional** circumstances, such as the rare situation where a certifying doctor is unavailable, for a significant length of time, to correct errors in the MCCD and satisfactorily complete the registration of the death.

Reasonable differences of clinical opinion should not be a cause to provide a replacement MCCD. NRS is of the view that any changes required to be made to the original MCCD by revision or replacement should always be undertaken by the original certifying doctor. If significant errors need to be corrected, a replacement MCCD may be provided by another doctor in rare circumstances, by asking another

²²<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

doctor to step in the certifying doctor's place e.g. the certifying doctor has left the country for a long time, is incapacitated (including suspensions), or is deceased. Sometimes a clinical member of the team with knowledge of the patient and/or access to the clinical records may be asked by the registrar to provide information/clarification of simple administrative queries/errors/omissions (as described in the second example below). Examples of some situations which may arise have been included below for clarification.

- The sort of errors for which registrars regularly send informants back to the original certifying doctor include missing signatures, blank or incomplete causes of death, and obviously out of order causes of death. The certifying doctor will provide a revised or replacement MCCD, including a signed and dated note specifying the amendments attached to the MCCD or signed and dated annotations on the original MCCD. If the certifying doctor is not available, the revised or replacement MCCD, including a signed and dated note specifying the amendments attached to the MCCD or signed and dated annotations on the original MCCD, may be provided by another doctor who has knowledge of the deceased and/or has access to the relevant clinical records as a contingency provided by the system.
- In many cases where an MCCD is not selected for a review, registrars can assess the MCCD as lacking some detail in the administrative (not clinical) information e.g. postcode missing. In these circumstances, rather than inconveniencing the family, the registrar will phone the certifying doctor to clarify the proper intent and correct this on the original MCCD. When registrars amend administrative data on the MCCD, to prevent the form from being sent back to the certifying doctor, it is always at the explicit instruction, and with the explicit permission, of the original certifying doctor. It would **not** be legally compliant if a member of the clinical team with knowledge of the patient and/or access to the clinical records instructs the registrar to amend an MCCD if the actual certifying doctor is available somewhere, **no matter how awkward it maybe to contact the doctor**; but it would be legally compliant if the certifying doctor is genuinely unobtainable.

- Where an MCCD is under review and substantial changes, or a replacement MCCD, is required by the MR, NRS would accept a revised MCCD (such as a signed and dated note appended to the original MCCD, or a signed and dated annotation on the original MCCD), or a replacement, from the certifying doctor or another qualified medical practitioner, who has knowledge of the deceased and/or has access to the relevant clinical records, if the original certifying doctor is unavailable (moved away, deceased, etc.). Registrars are **not allowed** to make alterations to the clinical parts of the MCCD, even at your direction. In such situations, for the benefit of the system records and the district examiners, who scrutinise each entry, after registration of the death, registrars will put a note into their Forward Electronic Register (FER) system, about the changes made, including the fact that the MCCD had been revised or replaced by another appropriate doctor as the original certifying doctor was unavailable to undertake the changes required by the MR. This is the same situation if changes are required for an MCCD which is not selected for review

9. CHANGING THE PUBLIC RECORD OF THE CAUSE OF DEATH

As mentioned in section 5.3, NRS may ask you to provide additional information about the causes of the death. This is solely to enable NRS to classify the death accurately for the purpose of the statistics that it produces. NRS does not change the public record of the cause of the death on the basis of the information that you provide in response to its requests.

There are only two ways in which the public record of the cause of a death can be changed.

Firstly, following the report of the death to the PF, if further clinical investigations after the PF instructed post mortem examination change the initial cause of death, the PF will advise NRS what the amended cause of the death should be. The procedures in place for how this is done can be obtained from NRS.

Secondly, a doctor may complete a second MCCD for the death as described below.

To change the public record of the cause of a death, you should complete a replacement MCCD in respect of the death, and send the form to the local registration office. The registrar will then arrange for the local office record of the death to be changed, and pass the information on to NRS, who will update its records. NRS will also inform the person who registered the death that the cause of the death has been changed, and how to obtain revised copies of the certificate of the registration of death.

In these circumstances, any doctor can complete a replacement MCCD in respect of a particular death, and it does not have to be done by the doctor who originally certified that death. So, for example, a Consultant in charge of the care of the deceased may complete a second MCCD in respect of a death that was originally certified by a doctor undertaking postgraduate training and who has since moved to another hospital.

You should only complete a second MCCD in cases where you believe that the change in the cause of death is likely to be regarded as "significant" by the relatives or by another interested party (such as an insurance company). **Please do not complete a second MCCD if the change is one that most people would be likely to regard as "minor"** (e.g. to specify more precisely the type of cancer, or to correct a grammatical mistake), **unless you believe that making the change is important to the relatives or to another interested party**. Changes which have to be made to improve the accuracy of the mortality statistics, without altering the public record of the cause of death, should be specified either in your responses to enquiries from NRS or by writing to the NRS Vital Events Statistics branch (at Ladywell House, Ladywell Road, Edinburgh EH12 7TF).

As mentioned earlier, NRS does not change the public record of the cause of the death on the basis of the information that you provide in response to its requests, because those details are supplied for statistical purposes only. Very occasionally, the nature of such information may make NRS staff consider that there is a case for considering a change to the public record of the cause of the death. If so, NRS may ask you to consider submitting a replacement MCCD in respect of that death. In such cases, it is for you to decide what (if any) changes should be made to the public

record, because NRS will not use information that was supplied for statistical purposes to change the public record. Please note that NRS will not suggest that you complete a replacement MCCD in cases where the death was reported to the PF, because NRS will expect the PF to indicate any changes that should be made to the public record of the causes of those deaths.

RELEVANT FORMS

MCCD (Form 11)



MCCD RECORD OF ISSUE



CURRENT CERTIFICATE OF REGISTRATION OF DEATH (Form 14) – to change from 29 April 2015 (to include information on Section D of MCCD)



CURRENT CERTIFICATE OF STILLBIRTH (Form 6) – to change (to include other information, including on Section D of MCCD)



CURRENT CERTIFICATE OF REGISTRATION OF STILLBIRTH (Form 8) – to change (to include other information, including on Section D of MCCD)



THE QUALITY ASSURANCE AND REVIEW OF MCCD

The [Certification of Death \(Scotland\) Act 2011](#)²³ is intended to improve the quality of MCCDs through quality assurance of the MCCD undertaken by an independent medical review system.

The aims of the legislation are to implement a new death certification system in Scotland which will introduce a single system of independent effective scrutiny, applicable to all deaths that do not require to be reported to the Procurator Fiscal; to improve the quality and accuracy of MCCDs; to strengthen clinical governance in relation to deaths; and to provide improved public health information.

There are 2 levels of random independent reviews of the MCCD

Level 1 - a basic shorter review of currently 10% of eligible deaths

Level 2 - a comprehensive review of about 2,000 deaths per year (around 4%)

The MCCDs for review will be selected at random by NRS, at the time the death is registered by the informant. You are required to complete the MCCD promptly as death registration cannot be finalised until the review process has been completed. The review will normally be completed in one working day (for Level 1 reviews) or 3 working days (for Level 2 reviews), depending on the level of the review. An MCCD may also be selected for review by a MR, following consideration of a request by an interested party such as a family member.

Further information, including the Scottish Government guidance, is also available on the [relevant sections](#)²⁴ of the Scottish Government website.

1. Medical Reviewer (MR)

The reviews will be undertaken by MRs, under the supervision of a SMR, all of whom are employed by Healthcare Improvement Scotland (HIS), and supported by MRAs.

²³ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>
²⁴ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

The statistical analysis will be undertaken by a statistical team as specified in legislation. This team is part of ISD.

2. Level 1 reviews

The main purpose of Level 1 review, which is a shorter review, is to improve the quality of the MCCD, for deterrence of poor and mal practice, and for public reassurance. In a Level 1 review, the MR will check the cause of death, and query anything unusual. This involves checking the MCCD and speaking to the certifying doctor (or another doctor in the team), usually by telephone, to obtain background clinical information.

Level 1 reviews will allow for any discrepancies to be picked up and can act as a trigger for a comprehensive Level 2 review. Some of the criteria for upgrading include:

- non-standard cause of death stated
- the sequence for the cause of death does not appear to be logical
- the registrar has referred an individual case for review where they have stated a particular concern about the medical cause of death
- feedback from ISD of relevant trends.

In the rare circumstances where no such other doctor is available, the MR will refer the case to the SMR.

3. Level 2 reviews

This thorough more comprehensive review of all available information allows the MR to come to a view about whether or not the MCCD is “in order” and provides information for the quality improvement programme for the new death certification system, while also providing an amount of deterrence.

The checks include reviewing the MCCD and speaking to the certifying doctor (or another doctor in the team), usually by telephone, to obtain background clinical information. In addition, the MR will consider relevant documents associated with

the death, including appropriate health records, and the results of any clinical investigations. The case may be discussed with other relevant clinical and health care staff, as required. The MR may also discuss the case with the family of the deceased or an informal carer, if required, through the most suitable means such as, telephone, face-to-face, or electronic methods of communication. Other relevant evidence may also be considered, such as viewing the body (this may rarely be necessary).

If when trying to discuss a certificate the relevant medical practitioner is unavailable or incapacitated, the MR will discuss the MCCD with another doctor in the team with knowledge of the case and access to the clinical records (in the case of junior doctors this should be another doctor in the team with knowledge of the case and access to the clinical records, or with a senior doctor who is the relevant Medical/Clinical/Educational Lead). In the rare circumstances where no such other doctor is available, the MR will refer the case to the SMR.

If, after conducting a review, the MR has come to the view that the MCCD is not in order, and the relevant medical practitioner is unavailable or incapacitated to provide a replacement certificate, the MR will refer the case to the SMR.

Under [Section 14 of the 2011 Act](#)²⁵, the MR can “require any person who is able, in the opinion of the Medical Reviewer, to produce relevant documents (including health records), to do so”.

4. Medical Reviewer Assistant (MRA)

MRs will be assisted in their duties and tasks by the MRAs. The MRA will prepare the randomised MCCD by NRS for review. This will involve setting up the conversation between the MR and the certifying doctor, and additional preparatory work for Level 1 and Level 2 reviews.

²⁵ <http://www.legislation.gov.uk/asp/2011/11/section/14>

The MRAs will be the first point of contact for queries for the MR office and organise the work of the MRs. MRAs will also arrange for the transfer of medical records, obtaining documents, setting up meetings between relevant people and the MRs and gathering other relevant information for the MR. MRAs will link closely with local authority registrars, the Funeral Directors and the Procurator Fiscal Office.

The MRA will ensure that ISD receives reports required for monitoring purposes. The MRA will also be responsible for data management of any clinical records and other data used for the review and the safe retention of any patient identifiable information held by them.

5. Senior Medical Reviewer (SMR)

The SMR will review any certificates where the MR is of the opinion the MCCD is not in order, and the certifying doctor is unable or unwilling to provide a replacement certificate, or if there is any ongoing disagreement between the MR and the certifying doctor, or in rare instances there is no doctor to provide information on the relevant case.

The SMR also provides any advice and guidance to the MRs as necessary.

If the MR identifies any concerns around quality and behaviour of a doctor when conducting a review, the MR and the SMR will bring these to the attention of the Medical Director/Clinical Director of the relevant Health Board and/or the Responsible Officer of the GMC. The MR and the SMR will request confirmation that the concern has been discussed with the certifying doctor and what action has been taken.

ISD statisticians will also provide the MRs, SMR and the Medical Directors of Health Boards with statistical information on death data for the relevant Health Board area/s. MRs will use this data to identify any additional cases for review based on triggers such as missing data, and incorrect forms. These clinical governance issues will be discussed with the relevant Medical Director/Clinical Director of the Health Board and/or the Responsible Officer of the GMC.

When conducting the review, the SMR will reflect on the links to clinical governance processes of NHS Boards, and record and reflect on any themes which arise from the different types of reviews. These could include recurrent quality issues in certain areas of certification or evidence that practice may be in need of review in certain departments, hospitals or GP practices. The SMR will also note their views on any training issues in relation to completion of MCCDs. The SMR will bring this to the attention of the relevant Medical Directors (or appropriate other officers) of the Health Boards. Death certification could be one of the areas included in the annual appraisal discussion of doctors.

6. *Unsatisfactory reviews*

If the review with the MR is satisfactory, the electronic Case Management System (eCMS) used by the MRs and SMR, will trigger a real time update to the registrar's FER system. The registrar will complete the registration process and issue Form 14 to the informant or the funeral director to enable the funeral to proceed.

If however, the MR decides that the MCCD is not in order, the MR will request that a replacement MCCD be issued by you, as the certifying doctor, with the agreed corrections, or an addendum (a signed and dated additional note with the corrections to the original MCCD) can be sent to the MR, usually scanned and sent by email for a further check. The MR will notify you when the check is scrutiny is completed, so that you can post the original documents (replacement MCCD or the note with the alterations) to the registrar. The eCMS will trigger a real time update from the MR to the registrar's FER system. The registrar on receipt of the documents posted by you to her/him will replace the original MCCD (in the case of a replacement MCCD) or attach the addendum to the original MCCD (in case of an additional note). Reasonable differences of clinical opinion, even with the MR or SMR should not be a cause to provide a replacement MCCD.

If you do not agree to make any corrections, the MR will refer the case to the SMR who will undertake another Level 2 review of the case and contact you. If you and the SMR agree that some changes are required, the process followed will be as in paragraph above. If however, you do not agree with the SMR, the SMR will

complete the review and the eCMS will trigger a real time update to the registrar's system, which will allow the registrar to proceed with registration on the basis of your original MCCD. The incident will be reviewed as a case study or a significant event and if appropriate, brought to the attention of the Clinical/Medical Director of your Health Board and their clinical governance procedures. MCCD reviews (positive reviews and learning needs) may be included in the doctor's appraisal and revalidation processes.

Please note that an MR must report any suspicion of criminality arising from the review to the PF, under [Section 16 of the 2011 Certification of Death \(Scotland\) Act 2011](#)²⁶.

If the MR or the SMR is of the view that the death is not one under Section 16 as above, but is otherwise reportable to the PF, the certifying doctor should then report this death to the PF.

Training resources for doctors and information for non-certifying staff and the public, developed by NHS Education for Scotland will be available and accessible through appropriate formats and routes.

7. *Post mortem examinations*

MRs and SMR do not have the powers to request or require a post mortem examination. Post mortem examinations can only be required by the PF in deaths reported to them. Hospital staff can also undertake post mortem examinations if clinically indicated, in non-PF cases, with the consent of the next of kin/person with the power of attorney/executor of the will.

MRs and SMR can only agree to a request for a post mortem examination in some relevant cases of people who have died abroad and have been repatriated to Scotland. This is set down in Section 19(1) of the Certification of Death (Scotland) Act 2011. In this situation, the MRs/SMR may access electronic records of the

²⁶ <http://www.legislation.gov.uk/asp/2011/11/section/16>

deceased and contact the person's General Practitioner or relevant hospital clinician for clinical details, prior to making a decision.

8. "Interested Persons" reviews

[Section 4 of the Certification of Death \(Scotland\) Act 2011](#)²⁷ allows specified "Interested Persons" to request the MRs for a review of the MCCD if they satisfy certain criteria laid down in legislation e.g. the definition of "Interested Person"; that the death did not occur more than three years previously; that it does not pre-date the implementation of the 2011 Act (April 2015); and that a review has not already been conducted on an eligible MCCD, as below.

The "Interested Person" will be advised by the MR/SMR to use other appropriate processes, e.g. the NHS Complaints procedures, for issues outside the remit of the review system, such as concerns regarding the care of an individual.

9. Not Staying Registration - "Expedited" process for reviews

An informant may apply for the review to "not stay registration" (expedited process for review) under sections [6 and 7 of the Certification of Death \(Scotland\) Act 2011](#)^{28/29}. An application must be made to the MR before the review is complete by a form available from the registrar. If the request is granted within 2 hours, registration of the death may go ahead if the MCCD is considered by the MR to be "in order", while the full review continues to be carried out. This will allow the burial, cremation, or other methods of disposal of the deceased person's body. If the informant requests an expedited review, this must be under one or more of the following categories:

- for **religious or cultural reasons** - for example, some religious traditions require burial within 24 hours and some communities have a tradition of burial within 3 days

²⁷ <http://www.legislation.gov.uk/asp/2011/11/section/4>

²⁸ <http://www.legislation.gov.uk/asp/2011/11/section/6>

²⁹ <http://www.legislation.gov.uk/asp/2011/11/section/7>

- for **compassionate reasons** - for example, in the death of a child under 16 years where a delay may cause significant additional distress
- for **administrative or practical reasons** - for example, where the family does not reside in Scotland and the deceased will be in transit to another part of the UK or international destinations for a funeral

10. Repatriated bodies from outside the UK

If a person dies outside the UK and is to be disposed in Scotland, Healthcare Improvement Scotland (HIS) is required [under sections 17-19](#)^{30/31/32} of the Certification of Death (Scotland) Act 2011 to verify a foreign death certificates, confirm the identity and check other relevant papers and MRs to authorise cremation, and agree to a post mortem examination where:

The applicant can be a person who wishes to arrange the interment, cremation or disposal by other means of the deceased; or the person in charge of the place where the deceased is to be interred, cremated, or disposed of by other means. The MR has to undertake a review, such as contacting the GP practice where the deceased was registered or the Consultant in charge of the care in Scotland prior to death. The MR must provide an authorisation to dispose, including to cremate, including information of “hazards” for cremation and the handling of the body. In the unusual circumstances where the cause of death is not known, despite all the enquiries, the MR can request a post mortem examination. The Procurator Fiscal has no jurisdiction to investigate deaths abroad except in very limited circumstances where the death is the result of an act of terrorism or is of a serviceman/woman serving abroad. In all other circumstances the Procurator Fiscal has no jurisdiction to instruct a post mortem or to direct any inquiry into the death.

³⁰ <http://www.legislation.gov.uk/asp/2011/11/section/17>

³¹ <http://www.legislation.gov.uk/asp/2011/11/section/18>

³² <http://www.legislation.gov.uk/asp/2011/11/section/19>

11. Pandemic Flu

The [legislation](#)³³ enables the scrutiny process to be suspended in certain circumstances such as epidemics or pandemics, such as Pandemic Flu.

[Specific guidance Chief Medical Officer Directorate and Police and Community Safety Directorate of the Scottish Government](#)³⁴ has been provided regarding death certification in the event of pandemic flu

12. NRS feedback to Health Boards

NRS sends datasets weekly to Health Boards, which include: the names and addresses of the deceased, the certifying doctor and the deceased's own doctor; the description of the cause of death (as given in Part I), plus all the ICD10 codes which NRS has allocated (including any based on Part II); and other information from the MCCD and the death registration process. Some of what you provide is held in a coded form in five variables called -

DICDSUPP0, DICDSUPP1, DICDSUPP2, DICDSUPP3 and DICDSUPP4.

For example, where any one of these variables has a code 12 the "M1 box" would have been ticked by the certifying doctor. Similarly a code 13 indicates that the "M2 box" has been ticked. This will enable Health Boards to track certain deaths in their areas such as deaths related to pregnancy.

The Statistician, Vital Events Statistics, at NRS is happy to be contacted for further details of what NRS provides to Health Boards at the address and email below:

Statistician, Vital Events Statistics, National Records of Scotland Ladywell House,
Ladywell Road, Edinburgh | EH12 7TF

Email: <http://www.gro-scotland.gov.uk/enquiries.html>

³³ <http://www.legislation.gov.uk/asp/2011/11/section/2>

³⁴ <http://www.scotland.gov.uk/Resource/Doc/1094/0053368.pdf>

RELEVANT LINKS

Access to Health Records Act 1990 - <http://www.legislation.gov.uk/ukpga/1990/23/section/3>

Battery powered and other implants that could cause problems during cremation (Annex A) - <http://www.justice.gov.uk/downloads/burials-and-coroners/cremations/cremation-applicants-guidance.pdf>

General Medical Council (GMC) website - http://www.gmc-uk.org/guidance/good_medical_practice.asp

GMC Good Medical Practice - http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0414.pdf

Guidance on Part 2 - Notifiable Diseases, Notifiable Organisms and Health Risk States of The Public Health etc. (Scotland) Act 2008 - <http://www.scotland.gov.uk/Topics/Health/Policy/Public-Health-Act/Implementation/Guidance/Guidance-Part2>

NHS Education for Scotland (NES) has developed some educational resources - [http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/generic-training/support-of-national-training/the-certification-of-death-\(scotland\)-act-2011-education-and-learning-resources.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/generic-training/support-of-national-training/the-certification-of-death-(scotland)-act-2011-education-and-learning-resources.aspx)

National Records of Scotland (NRS) link in the MCCD - <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

NHSScotland Guidance on Patient Confidentiality - <http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4011563/Revised%20Code%20of%20Confidentiality%20-%20Final.pdf>

Paragraphs 70-72 GMC Guidance on Confidentiality - http://www.gmc-uk.org/static/documents/content/Confidentiality_-_English_0414.pdf

PF Guidance - "Reporting Deaths to the Procurator Fiscal, Information and Guidance for Medical Practitioners" - <http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

Registration of Births, Deaths and Marriages (Scotland) Act 1965 - <http://www.legislation.gov.uk/ukpga/1965/49>

Relevant sections of the Scottish Government website - <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

Section 4 of the Certification of Death (Scotland) Act 2011- <http://www.legislation.gov.uk/asp/2011/11/section/4>

Specific guidance Chief Medical Officer Directorate and Police and Community Safety Directorate of the Scottish Government -
<http://www.scotland.gov.uk/Resource/Doc/1094/0053368.pdf>

The Certification of Death (Scotland) Act 2011 website -
<http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

The guidance for doctors on Good Medical Practice (paragraph 71) -
http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0414.pdf

The HSE guidance - <http://www.hse.gov.uk/pubns/web01.pdf>

The legislation enables the scrutiny process to be suspended in certain circumstances such as epidemics or pandemics, such as Pandemic Flu -
<http://www.legislation.gov.uk/asp/2011/11/section/2>

The list of notifiable diseases is contained in Schedule 1, part 1 of the Public Health etc. (Scotland) Act 2008 -
http://www.legislation.gov.uk/asp/2008/5/pdfs/asp_20080005_en.pdf

Under sections 6 and 7 of the Certification of Death (Scotland) Act 2011 -
<http://www.legislation.gov.uk/asp/2011/11/section/6>
<http://www.legislation.gov.uk/asp/2011/11/section/7>

Under Section 14 of the 2011 Act -
<http://www.legislation.gov.uk/asp/2011/11/section/14>

Under Section 16 of the 2011 Certification of Death (Scotland) Act 2011 -
<http://www.legislation.gov.uk/asp/2011/11/section/16>

Under sections 17-19 of the Certification of Death (Scotland) Act 2011 -
<http://www.legislation.gov.uk/asp/2011/11/section/17>
<http://www.legislation.gov.uk/asp/2011/11/section/18>
<http://www.legislation.gov.uk/asp/2011/11/section/19>